IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, M.D., et al.,
Petitioners,
v.

LOUIS W. SULLIVAN,
Secretary of Health and Human Services,
Respondent.

THE STATE OF NEW YORK, et al.,
Petitioners,
v.

LOUIS W. SULLIVAN,
Secretary of Health and Human Services,
Respondent.

On Writs of Certiorari to the
United States Court of Appeals
for the Second Circuit

BRIEF OF FEMINISTS FOR LIFE OF AMERICA AND AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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BRIEF OF FEMINISTS FOR LIFE OF AMERICA AND AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS AS AMICI CURIAE IN SUPPORT OF RESPONDENT

INTEREST OF THE AMICI

Feminists of Life of America ("FFLA") has its national headquarters in Kansas City, Missouri and state chapters throughout the nation. FFLA engages in educational activities, lobbying and advocacy designed to foster respect for human life and social and economic justice for women. FFLA recognizes that much of the support for abortion on demand as a "solution" for crisis pregnancies stems from motives that are far removed from women's welfare, and that this reality is demonstrated in the abusive practices that have flourished at abortion clinics since the legalization of abortion in 1973. Moreover, FFLA members believe that the widespread availability of abortion provides a disincentive to responsible sexual behavior and use of preconception family planning.

The American Association of Prolife Obstetricians and Gynecologists (AAPLOG) is a national organization of obstetricians and gynecologists founded in 1973 and dedicated to reaffirming the unique value and dignity of individual human life in all stages from the moment of conception. The organization is engaged in educational and research projects which enhance the goals of the organization. AAPLOG has particular concerns regarding the impact on maternal health of abortion on demand, and the prevalent use of abortion as a means of family planning or birth control. AAPLOG believes that lax enforcement of Title X's restriction upon the use of abortion as a method of family planning has allowed abortion to become a component of the largest government-supported family planning program, further eroding public respect for human life, and advancing the notion that abortion is an acceptable means of family planning.

STATEMENT

Title X of the Public Health Service Act was enacted in 1970 to provide federal support for preventive family planning services. Section 1008 of Title X expressly prohibited the expenditure of Title X funds in any program where abortion is a method of family planning. 42 U.S.C. § 300a-6.

The Office of Population Affairs of the Department of Health and Human Services proposed regulations in 1987 to enforce the specific mandate of Section 1008. These were the first HHS regulations directed to this issue. Department policy toward Section 1008 had previously been expressed through internal memoranda, and a series of Guidelines published in 1981.

The final regulations were issued in February, 1988. 53 Fed. Reg. 2944, 2946 (1988), 42 C.F.R. §§ 59.2, 59.7, 59.8, 59.9, 59.10 (hereinafter referred to as "new Regulations"). The new Regulations, among other things, require Title X clinics to refer their pregnant clients to appropriate prenatal and social services that promote the welfare of the mother and unborn child. Such referrals cannot be used to steer women to providers whose principal business is performing abortions. Where a medical emergency relating to pregnancy exists, the client is to be referred immediately to a provider of emergency care. 42 C.F.R. § 59.8.

To maintain the integrity of the Title X program, the new Regulations also require that the program be organized so that it is physically and financially separate from activities which are prohibited by Section 1008 and related regulations. 42 C.F.R. § 59.9. In addition, Title X program funds may not be used for political, lobbying and advocacy activities relating to abortion. 42 C.F.R. § 59.10. The foregoing requirements apply to an entire Title X program, and not merely to the portion of funding of that program which is contributed by the federal government. 42 C.F.R. § 59.2.

SUMMARY OF ARGUMENT

Section 1008 of Title X broadly prohibits the expenditure of Title X funds in programs where abortion is a method of family planning. Since the nationwide legalization of abortion, *Roe v. Wade*, 410 U.S. 113 (1973), the need for vigilant enforcement of Section 1008 has grown. Abortion is widely advocated and employed as a method of family planning, as illustrated by the fact that almost 43 percent of abortions are performed upon women who have previously had at least one abortion.

Previous policies and guidelines regarding compliance with Sec. 1008 have been inadequate. Thus, Title X clinics have been permitted to share facilities with abortion clinics, and to engage in counseling and referral practices which a 1982 report of the Comptroller General concluded were "questionable" in light of Section 1008. Furtherfore, the requirement imposed by HHS in 1981 that Title X clinics engage in "options counseling" of their pregnant clients has effectively permitted such clinics to incorporate abortion as a means of family planning into the counseling and referral component of their services. The training literature and counseling practices of such clinics affirmatively treat abortion as a family planning option, and even state that this option must be discussed with clients who are not even pregnant. Furthermore, training materials propose counseling strategies which encourage women who are ambivalent about a decision to abort to go ahead with that decision.

The new Regulations are thus essential to preserve the strict dichotomy that Congress intended to exist between Title X programs on the one hand, and abortion on the other. These regulations do not pose any risk to maternal or child health. Elective abortions, chosen as a means of family planning or birth control, constitute over 95 percent of abortions performed annually. The abortion destroys the life of the unborn child, and poses risks of both physical and psychological harm to the mother—

risks which were not required to be disclosed under the former "options counseling" Guidelines. Thus, by prohibiting referral to facilities whose primary purpose is the performance of elective abortions, the new Regulations protect, rather than harm, maternal and fetal health interests.

Furthermore, in those cases where a medical indication for abortion does exist, appropriate diagnosis, care and counseling can only be performed by an expert in the woman's underlying medical condition. Neither Title X clinics, nor clinics specializing in abortion services, are equipped to offer such expertise. Thus, when a client of a Title X clinic is diagnosed as pregnant, and she suffers from a condition that could complicate the pregnancy, the clinic should immediately refer her to a specialist in that condition. The new Regulations clearly permit this course of action.

Because of the specific nature of the amici's interests in this case, their argument is directed to Sections 59.2, 59.7, 59.8, and 59.9 of the Regulations. The amici, however, support all of the challenged regulations, in their entirety.

ARGUMENT

I. SINCE ABORTION IS COMMONLY EMPLOYED AS A METHOD OF FAMILY PLANNING, AND HAS BEEN SO EMPLOYED BY MANY PROGRAMS RECEIVING TITLE X FUNDING, THE NEW TITLE X REGULATIONS ARE ESSENTIAL TO ENFORCE THE STATUTORY PROHIBITION ON FUNDING ABORTION AS A MEANS OF FAMILY PLANNING.

A. Section 1008 is a Broad Prohibition of Funding of Any Program In Which Abortion Is a Method of Family Planning.

In 1970, when Title X of the Public Health Service Act [1] was first enacted, abortion was advocated,[2] but was

[1] 42 U.S.C. § 300 *et seq.* (1982).

[2] The Senate debate on Title X records statements of several national organizations which candidly endorsed abortion as a means of family planning. 116 Cong. Rec. 24097-24101 (July 14, 1970) (statement of Sen. Packwood). Legal abortion was encouraged: "to assure the accepted right to determine freely the number and spacing of . . . children" (American Public Health Association); "as a back-up medical technique to omitted or failed contraception" (Planned Parenthood); and to protect a woman's "right to decide whether to terminate a particular pregnancy she does not wish to carry to term" (Citizen's Advisory Council on the Status of Women). *Id.* at 24097-24098.

not widely available or utilized as a means of family planning.[3] The framers of Title X recognized the potential that a nationwide, comprehensive program of family planning services could, without specific limitation, endorse abortion as a means of family planning.[4] The

[3] Despite some claims in the record of this case to contrary, *Cf.* Katz Affidavit, ¶ 12, J.A. 205, 209, abortion was not widely available at the time, being prohibited or greatly restricted in 46 states. *See,* Linton, *Enforcement of State Abortion Laws After* Roe: *A State-by-State Analysis,* 67 U. Det. L. Rev. 157 (1990) (analyzing laws in effect as of January 22, 1973). Thirty states allowed abortion only to save the life of the mother; two states and the District of Columbia allowed abortion only to preserve the life or health of the mother; one state allowed abortion to save the life of the mother or to terminate a pregnancy resulting from rape, and thirteen states allowed abortion to save the life or physical or mental health of the mother, to terminate a pregnancy resulting from rape or incest, or to terminate a pregnancy when the unborn child may be severely mentally or physically disabled. *Id.* at 162-236, 258.

The remarks of Representative Dingell, in support of Section 1008, stated that "[n]one of the 50 states currently sanction abortion as a method of family planning." 116 Cong. Rec. 37379 (1970) (statement of Rep. Dingell). The uniformity of legal opposition to abortion at the time prompted him to note that "[f]or the Congress of the United States to appropriate funds for a procedure which would violate the criminal law of a vast majority of American jurisdictions would be to raise constitutional questions of a most serious nature." *Id.*

[4] 116 Cong. Rec. at 37371 (Nov. 16, 1970) (statement of Rep. Pickle) ("Given the urgency of the population problem, the temptation to use scare tactics and to trammel on the beliefs of others is easy to see."); 116 Cong. Rec. at 37368 (Nov. 16, 1970) (statement of Rep. Carter); 116 Cong. Rec. at 37375 (Nov. 16, 1970) (statement of Rep. Broyhill).

House version of Title X thus included a provision "making it clear that no funds appropriated under the legislation may be used in programs where abortion is a method of family planning." [5] This provision was eventually agreed upon by the House-Senate conferees, and enacted as Section 1008 of Title X.[6]

Consistent with the intent of Title X to provide omnibus *family planning* services,[7] Section 1008 is phrased broadly. It should likewise be applied broadly, to *any* aspect of any program funded by Title X. From its outset, Title X was multi-faceted, involving financial support for direct family planning services, training of family planning specialists, and research into the biology of human reproduction, the development of contraceptives, and the social and behavioral aspects of population.[8] Thus, the drafters contemplated that Title X "programs" would include more than simply the prescription of contraceptive drugs and devices, or the performance of medical procedures.[9] Indeed, some funded programs, including those involving education and research, might not engage in these functions at all.

[5] Family Planning Services and Population Research Act of 1970, H. Rep. 91-1472, *reprinted in* 91 U.S. Code, Cong. & Admin. News 5068, 5070 (1970) ("House Report").

[6] 42 U.S.C. § 300a-6.

[7] The arguments of Petitioners and several *amici* suggest that Title X was enacted to provide comprehensive *health care* services to women. The legislative history of Title X is devoid of any such suggestion. The House and Senate floor debates indicate that Title X was enacted to meet two perceived needs: first, the social need for research, education and funding on issues of human reproduction and population; and second, the need for families, particularly the poor, to have access to voluntary family planning services. *See generally*, 116 Cong. Rec. 24089-24101 (Senate); 116 Cong. Rec. 37375-37393 (House).

[8] House Report, *supra* note 5 at 5070-5071.

[9] S. Rep. No. 91-1004, 91st Cong., 2d Sess. 10 (1970) *reprinted in* 116 Cong. Rec. 24094, 24096 (1970) ("Senate Report") (Title X program should include "medical services, including consultation, examination, prescription and continuing supervision, supplies, instruction and referral to other medical services as needed

Accordingly, the Congressional mandate that no Title X funds "shall be used in *programs* where abortion is a method of family planing," cannot be read simply to prohibit the performance of abortions in funded programs. Rather, this prohibition must extend to all aspects of a Title X program. Clearly, where an entity operating a Title X clinic shares its facilities with an abortion clinic, or uses its own personnel to perform abortions when the Title X program is purportedly "closed," the strictures of Section 1008 are violated.[10] This is also true if the clinic counsels that elective abortion is a back-up to contraceptive failure, or routinely refers its clients to clinics which are primarily or exclusively engaged in performing abortions. In each of these scenarios, abortion is treated as a method of family planning.

Section 1008 would be a hollow prohibition if a clinic could escape its grasp by excluding abortion from its range of medical services, while including abortion as a part of its referral and counseling services. Since Congress clearly recognized the breadth of the word "program" as used in Section 1008, and prohibited the funding of "programs" where abortion is a method of family planning, appropriate enforcement of Section 1008 would require the Secretary to look at *all* aspects of a program—not just its direct delivery of medical services—in making the determination of compliance with Section 1008. The regulations at issue are consistent with this requirement.

. . . [an] outreach/follow-up system, including patient identification, contact, recruitment, appointment support, follow-up, and continuing education.")

[10] Comptroller General of the United States, *Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification*, General Accounting Office, Report No. GAO/HRD-82-106 (1982), at 7-10, J.A. 82, 100-103 (Hereinafter cited as "Report").

B. Abortion Is Widely Used As a Method of Family Planning.

Contrary to the situation prevailing in 1970, abortion is now legal, virtually throughout pregnancy, in all 50 states. As a result, it is commonly used, even on a repeat basis, as a means of family planning.

Abortion is the most commonly performed surgical procedure in the United States. One and one-half million abortions are performed each year, a preponderance of these at the approximately 820 freestanding clinics devoted primarily to this purpose.[11] Despite widespread confusion over the "medical" aspects of abortion, the fact is that over ninety-five percent of abortions are performed because the mother has determined, for non-medical reasons, that she does not want to be pregnant and/or to bear a child at that particular time.[12]

The use of abortion as a means of family planning has dramatically increased since the nationwide legalization of abortion. *Roe v. Wade*, 410 U.S. 113 (1973).[13] This

[11] Torres & Forrest, *Why Do Women Have Abortions?*, 20 Fam. Plan. Persp. 169, 169 (1988) (90 percent of abortions are performed at 819 clinics which each perform at least 400 abortions per year.)

[12] "[T]wo percent of all abortions in this country are done for some clinically identifiable entity—physical health problem, amniocentesis, and identified genetic disease or something of that kind." The remainder are elective, "performed on women who for various reasons do not wish to be pregnant at this time." *Constitutional Amendments Relating to Abortion: Hearings on S.J. Res. 17, S.J. Res. 18, S.J. Res. 19, and S.J. Res. 110 Before the Subcommittee on the Constitution of the Senate Committee on the Judiciary*, 97th Cong. 1st Sess. 158 (statement of Irwin M. Cushner, M.D., M.P.H.) *See also*, Torres & Forrest, *supra* note 11 at 170 (Of 1773 abortion patients surveyed, three percent cited maternal health considerations as most important factor for choosing abortion; one percent cited rape or incest.)

[13] *See* Wardle, *"Time Enough"*: Webster v. Reproductive Health Services *and the Prudent Pace of Justice*, 41 Fla.L.Rev. 881, 955, 985-986 (1989).

is illustrated by increases in both the abortion rate, and in the number of repeat abortions. For example, in 1974, approximately 899,000 abortions were performed in the United States, representing a rate of 19.3 per 1000 women of childbearing age.[14] Of these, 15.2 percent were upon women receiving at least their second abortion.[15] By 1985, approximately 1.6 million abortions were performed, and the rate had climbed to 28.0 per 1000 women of childbearing age.[16] More significantly, 42.9 percent of abortions performed in 1987 were upon women receiving at least their second abortion.[17] The rise in these figures has been consistent since the legalization of abortion in 1973.[18]

The vast preponderance of abortions are not performed for medical reasons, but due to factors exogenous to the pregnancy itself, such as the woman's age, socio-economic standing, family circumstances, and access to financial and family support for child-bearing and child-rearing.[19] These are precisely the circumstances which influence other "family-planning" decisions. For this reason, those entities and individuals who consider abortion to be a morally-neutral or even beneficial form of family planning now include abortion or abortion referrals among the range of family planning services that they offer. Indeed, the central thrust of Petitioners' arguments in this case is that abortion is a family planning option for a woman with an unplanned pregnancy.

[14] Henshaw, *et al., Abortion Services in the United States, 1979 and 1980*, 14 Fam. Plan. Persp. 1, 6 (1982).

[15] Forrest, Sullivan & Tietze, *Abortion in the United States, 1977-78*, 11 Fam. Plan. Persp. 329 (1979).

[16] Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plan. Persp. 63 (1987).

[17] Henshaw, *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients*, 20 Fam. Plan. Persp. 158 (1988).

[18] *See* Appendix.

[19] Torres & Forrest, *supra*, note 11.

and that this option must be offered to such women within the context of any family planning program.[20]

Title X, however, rejects this approach for government-funded family planning programs. Representative Dingell, in offering the amendment which became Section 1008, left no doubt that it was intended to exclude non-complying programs from Title X funding.

> During the course of House hearings . . . there was some confusion regarding the nature of the family planning programs envisioned, whether or not they extended to include abortion as a method of family planning. With the "prohibition of abortion" amendment . . . the committee members clearly intend that abortion is not to be encouraged or promoted *in any way* through this legislation. *Programs which include abortion as a method of family planning are not eligible for funds allocated through this act.*

116 Cong. Rec. 37375 (1970) (statement of Rep. Dingell). (Emphasis supplied). Furthermore, Representative Dingell pointed to evidence that the inclusion of abortion in Title X programs would provide a disincentive to the development and responsible use of preconception means of family planning, and thus, would be antithetical to the central purposes of Title X.[21] In light of the current practice of abortion on demand, a development which is facilitated by many providers of family planning services, the need for rigorous enforcement of the prohibition in Section 1008 exceeds that which existed at the time Title X was enacted.

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[20] *See* Brief of *Amici Curiae* Planned Parenthood Federation of America and National Family Planning and Reproductive Health Association [NFPRHA], at 6-7. More extensive discussion of the incorporation of abortion into government-funded family planning programs is provided in Section I (C), *infra*.

[21] 116 Cong. Rec. 37375 (1970) Representative Dingell cited statistics from other industrialized notions which demonstrated "that the prevalence of abortion as a substitute or a back up for contraceptive methods can reduce the effectiveness of family planning programs."

C. Under Previous HHS Guidelines, Title X Programs Have Violated Section 1008 by Treating Abortion As a Method of Family Planning.

Previous HHS program guidelines and practices have not adequately enforced the restriction in Section 1008. As a result, many Title X programs promote abortion as a family planning option to their pregnant clients, and some closely affiliate themselves with abortion clinics for the purpose of providing cross-referrals.[22] As a result, Title X funding has, prior to the current regulations, been employed to support programs where abortion is treated as a method of family planning.

1. *Section 1008 Has Not Been Adequately Enforced with Respect to Separation of Family Planning and Abortion Facilities*

A 1982 report by the Comptroller General of the United States documented both a lack of clear enforcement by HHS of Section 1008, and a pattern of clinic activities which, at the very least, blurred the distinction between abortion and family planning set forth in Title X funding has, prior to the current Regulations, HHS policy at that time permitted Title X recipients:

> to use organizational techniques to insulate the [T]itle X program from abortion activities prohibited by [S]ection 1008 and thereby not jeopardize their eligibility for [T]itle X funds. Because the distinction between the recipients' [T]itle X and other activities may not be easily recognized, the public can get the impression that Federal funds are being used improperly for abortion activities.[23]

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[22] Planned Parenthood and NFPRHA, which represent 85 percent of the agencies and organizations funded under Title X, candidly admit that counseling of abortion as a means of fertility control is an "integral part of any program that provides medically-based family planning services. . . . A woman choosing [certain] methods of family planning also needs information about the availability of abortion as a backup if contraception fails." *Amici* Brief, *supra* note 20 at 6.

[23] Report, *supra*, note 10, J.A. 85.

The Comptroller General noted that "74 organizations receiving [T]itle X funds perform abortions at clinics co-located with family planning programs." His report further noted that in certain clinics, counseling practices did not present alternatives to abortion, and educational materials presented abortion as a backup to barrier methods of contraception. The report concluded that there was a lack of clear policy guidelines on allowable and unallowable activities relating to abortion in Title X clinics.

Two examples cited by the Comptroller General demonstrate the lack of separation between abortion and family planning programs. In one case, the Title X grantee formed a separate corporation to provide abortion services, but maintained effective control over that corporation through interlocking directorship and the right to appoint trustees. The abortion clinic, which performed 1000 abortions per year, operated on the second floor of the same three-story building in which the family planning clinic also leased space. The two clinics operated simultaneously and shared an executive director, financial manager and other employees.[24]

In the second case, a Title X clinic offered abortion services only for the first 90 minutes of the business day, then subsequently operated a family planning clinic for the remainder of the day. The two clinics were operated by the same corporation and staffed by the same personnel. Furthermore, the abortion clients were counted as family planning clients for purposes of Title X reporting, and these abortion patients accounted for one-third of the total caseload.[25]

The record below establishes that such arrangements are not aberrational. Indeed, Petitioners contend that co-location of abortion and family planning services is mandated by Title X's goal of providing "comprehensive"

[24] J.A. 101-102.

[25] J.A. 102-103.

access to family planning services. Rust Brief at 49.[26] The directors of such "co-located" clinics candidly testified in the district court that such arrangements are "necessary" to provide adequate family planning services.

- The plaintiff, Dr. Rust, testified that his clinic provided family planning services to 7,138 patients in 1986, and performed 2,000 first trimester abortions during the same period. In his view, "integrated services are needed to facilitate enrollment in counseling and family planning programs." [27]
- A director of four affiliated Title X clinics testified that 70 percent of patients with positive pregnancy tests were referred for abortion, and that 80 percent of those patients obtained their abortions at the one affiliated clinic which provides abortions.[28]
- The director of a family planning project located at a hospital in New York City testified that pregnant clients who choose abortion "because of contraception failure, improper use of contraceptives, or for any other elective reason," or for medical indications, are referred for abortion to the area of the hospital where abortions are performed through the twentieth week of pregnancy.[29]
- The director of a non-profit clinic in Jersey City which receives 33 percent of its funding from Title X testified that, on an annual basis, 6,000 women receive family planning services, 4,000

[26] Even if Title X's general intent to provide comprehensive family planning services were relevant to this analysis, it is clear that the more specific dictates of Section 1008 control. Thus, the prohibition on abortion as a method of family planning would supercede the argument that such affiliations with abortion clinics are necessary to provide "comprehensive" family planning services.

[27] Rust Affidavit, ¶¶ 5, 18, J.A. 248, 249, 256.

[28] Drisgula Affidavit, ¶¶ 10, 11, J.A. 148, 150-151.

[29] Affidavit of Hiroko T. Felton, M.D., ¶¶ 9-12, *State of New York v. Bowen*, No. 88-6204 (2nd Cir. 1989) Joint Appendix, Vol. 2 at 524A, 526A-527A.

pregnant women receive "options counseling," and 1,538 abortions are performed. Appointments for abortions at the same clinic are arranged at the end of the counseling session. The director further testified that provision of abortion services alongside family planning and prenatal services "results in higher quality health care for women."[30]

Abortion services at these clinics are a part of the family planning program underwritten by Title X in four respects. First, abortions are sometimes performed in the same facility, as in the case of the Jersey City Clinic. Second, the funded entity is able to use its Title X program to provide a steady basis of client referrals for its abortion services. Third, Title X funds underwrite the counseling and referral for abortions provided on-site at the family planning clinic. Fourth, colocation provides the unavoidable appearance that abortion is accepted as a method of family planning by the Title X clinic. The view of Petitioners and their witnesses, that integration of abortion and family planning services is beneficial, serves only to underscore how far these providers have departed from the original intent of Title X. The fact that these Title X-funded programs, and scores of others, choose to operate in violation of the policy stated in Section 1008 establishes the need for these regulations.

2. *The 1981 HHS Guidelines Regarding "Options Counseling" Have Permitted Title X Grantees to Promote Abortion as a Method of Family Planning, In Violation of Section 1008.*

In 1981, HHS issued non-regulatory "Guidelines" for the operation of Title X programs.[31] According to the

[30] Affidavit of Marilyn Bennett, ¶¶ 8, 14, 24, J.A. 282-283 (Excerpts); Court of Appeals Joint Appendix, Vol. 2 at 494A, 496A, 502A (Full Affidavit).

[31] Department of Health and Human Services, Bureau of Community Health Services, *Program Guidelines for Project Grants for Family Planning Services* (1981). J.A. at 71a.

Guidelines, pregnant women should be offered counseling regarding their pregnancy, and those who request information on the "management" of their pregnancies "are to be given non-directive counseling on the following alternative courses of action, and referral upon request: pregnancy care and delivery; infant care, foster care or adoption; pregnancy termination."[32] The Comptroller General acknowledged these Guidelines, but concluded that Title X projects still lacked sufficient guidance on the level of permissible activity related to abortion.[33] Moreover, the Comptroller General documented that a large percentage of Title X clinics engaged in "questionable" counseling practices which had the effect of treating abortion as a method of family planning.[34] This extended as well to the referral practices of these clinics.[35] The Comptroller General recommended that "the Secretary establish clear operational guidance" on the activities relating to abortion that are or are not allowed.[36]

One reason that the 1981 Guidelines were insufficient is that they deviated from the original intent of Title X in two critical respects. First, they incorporated *post*-conception counseling and treatment into a program that was solely designed to support *preventive* family planning measures. Second, they institutionalized the practice of abortion counseling in the operation of a statute which expressly prohibits the funding of programs that promote abortion as a means of family planning.

It is not surprising, then, that these Guidelines have permitted counseling and referral for abortion to become

[32] *Id.*, Sec. 8.6.

[33] J.A. 116, 120.

[34] J.A. 114-115.

[35] J.A. 116-117.

[36] J.A. 121.

integrated into Title X-funded programs. The Comptroller General documented an existing bias in favor of abortion exhibited by a representative sample of Title X providers.[37] Further evidence is provided by the testimony in this case, and the training materials submitted to the Office for Population Affairs by Title X training and service grantees.[38] These materials illustrate that abortion is incorporated as a method of family planning at Title X clinics in the following specific ways: a fundamental commitment to the availability and use of abortion as a means of family planning; the presentation of abortion to the pregnant client as an option equivalent to prenatal care and childbirth; and the encouragement of abortion through the use of counseling techniques which affirm and support the decision-making process leading up to abortion.

The commitment to abortion is summarized in the testimony of Dr. Rust, stating that "[n]o responsible family planning decision can be made without information about every alternative available, including that of abortion, in the event that contraceptive failure occurs."[39] A widely utilized training guide published by a Planned Parenthood affiliate asserts that "the prevention of unwanted pregnancies and access to quality medical services, including legal abortion, are essential to reducing maternal and infant mortality."[40]

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[37] J.A. 114-118.

[38] Copies of these training materials were obtained from the Deputy Assistant Secretary for Population Affairs through a request under the Freedom of Information Act.

[39] Affidavit of Irving Rust, M.D. ¶ 9 (February 5, 1988) J.A. 248, 251.

[40] Saltzman & Policar, *The Complete Guide to Pregnancy Testing and Counseling*, 119 (Planned Parenthood Alameda/San Francisco 1985) (hereinafter cited as "Planned Parenthood Guide").

As a result of this commitment, and the policy reflected in the Guidelines, Title X training material presents abortion as one of three equivalent options for dealing with an unplanned pregnancy. In an HHS publication on counseling adolescents, counselors are recommended to review, with pregnant clients who have chosen abortion, issues such as scheduling, transportation, and payment for the abortion.[41] A policy promulgated by the North Dakota health department states that each delegate agency under that state's Title X program "should provide information to the client on all legal alternatives to problem pregnancy . . . encouraging her to examine the advantages and disadvantages of each of the legal options," including abortion.[42] A Planned Parenthood guide recommends that a counselor who has "strong feelings" in the case of a woman who uses abortion as her exclusive means of birth control, and is seeking her forth abortion, remain unbiased, and refer the woman to another counselor if necessary.[43]

Furthermore, although Title X and the 1981 Guidelines clearly prohibit the encouragement of abortion, significant portions of the Title X training material discuss methods for ameliorating negative feelings toward abortion. For example, the Planned Parenthood guide dis-

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[41] Spain, *Counseling Adolescents in Reproductive Health Care Settings*, (Department of Health and Human Services, Bureau of Community Health Service, 1980).

[42] Correspondence, Deb Arnold, Director of North Dakota Family Planning Program to Joyce Elmore, Director of Training, Office of Population Affairs, Department of Health and Human Services, December 14, 1989.

[43] Planned Parenthood Guide, *supra* note 40 at 24. The point of this example is not to argue whether or not counselors should allow personal bias to cloud their professional judgment in the counseling relationship. Rather, this example illustrates the extreme to which the "options counseling" ethic may be used to screen out *any* negative assessment of abortion as a means of family planning.

cussed above presents the hypothetical situation of a married woman who has agreed to have an abortion, but is having difficulty accepting the decision. The suggested responses include: "Tell her that no one makes the decision to have an abortion easily or ever feels really 'good' about it. Acknowledge that feelings of discomfort and sadness are normal; Ask about the reasons for which she and her husband decided on an abortion. Help her to reaffirm that this is the best decision for them right now; Remind her that feelings of guilt, sadness or loss do not mean that a wrong decision was made." [44] The HHS publication on counseling of adolescents notes that where a client experiences anxiety and guilt over her decision to abort, "the counselor may be able to reduce the intensity of the feelings *or the possibility of their interfering with commitment to the plans.*" [45]

The previous examples demonstrate that many grantees see no actual difference between "options counseling" and the encouragement of abortion. They demonstrate, in a concrete way, the justifiable concerns that led Congress to enact Section 1008.

II. THE NEW REGULATIONS ARE NECESSARY TO ENFORCE THE MANDATE OF SECTION 1008 AND POSE NO THREAT TO WOMEN'S HEALTH.

A. The New Regulations Are Essential to Enforce Section 1008.

Title X reflects "a fundamental dichotomy between the provision of preventive and other pre-pregnancy family

[44] Planned Parenthood Guide, *supra* note 40, at 24-25.

[45] Spain, *Counseling Adolescents*, *supra* note 41 at 88 (emphasis supplied). This 1980 HHS publication also suggests potential respouses to clients who fear alienation from their church over their abortion decision: "You're really worried that you're going to feel strange in church after having the abortion. What would help you with that strange feeling? . . . You pointed out to me that, even though abortion is against your religion, having a baby when you're not married is also." *Id.*

planning services, on the one hand, and abortion on the other." [46] This dichotomy has been breached due to: dramatic change in the legal status of abortion; providers embracing abortion as a means of family planning; and lack of direction in enforcing the restrictions of Section 1008. In recognition of changed circumstances, and the failure of previous efforts to effectively monitor program conduct, the new Regulations are necessary to preserve the "fundamental dichotomy" mandated by Congress.

1. As illustrated above, it is virtually impossible for HHS to permit (or require) abortion counseling, without compromising the restrictions of Section 1008. The Petitioners and certain *amici* argue that this inconsistency can be resolved by reading Section 1008 to prohibit *only* the direct funding of abortion with Title X grants. This Court is well acquainted with the ability of Congress to restrict funding for the purposes of *performing* abortions. *Harris v. McRae*, 448 U.S. 297 (1980). However, the language of Section 1008 is not so limited.[47] Current practice is largely in conflict with that language.

The appropriate solution, wholly consistent with the purposes of Title X, is to refer a client diagnosed as pregnant to those providers in the health care system who can meet her need for prenatal care and social services counseling. Section 59.8 of the new Regulations,

[46] 52 Fed. Reg. 33210 (Sept. 1, 1987).

[47] The Department has recognized this fact since the enactment of Title X. An internal memorandum from legal counsel dated April 1971 stated that a "literal" reading of Section 1008 would limit the prohibition to programs "in which abortions *are provided* as a means of family planning." (Emphasis in original). However, relying upon the legislative history, this "literal" interpretation was dismissed. "[I]t is apparent that the Congressional intent was to prohibit a broader scope of activity than a literal reading of section 1008 would require." Memorandum from J. Mangel, Deputy Asst. General Counsel, to L. Hellman, M.D., Deputy Assistant Secretary for Population Affairs (April 20, 1971) J.A. 35, 36-37.

which incorporates this requirement, does not disturb the ability of the Title X clinic to deliver, or the client to receive, the *preventive* family planning services which Title X was intended to support. Moreover, the referral requirement, by providing clear guidance to grantees on the permissible scope of post-pregnancy counseling, addresses a major concern noted by the Comptroller General.

2. The requirement of separation from abortion-related services is justifiable and essential to the integrity of the Title X program. In some instances, the provision of abortion services by a Title X grantee is a *de facto* component of the Title X program—a circumstance which offends even the crabbed interpretation of Section 1008 suggested by the Petitioners. In other instances, where the abortion services are arguably part of a separate "program," but are co-located with the Title X recipient, the opportunity for public confusion over the scope of the family planning program, and for indirect support of abortion services with government funds, is still present. Therefore, contrary to the arguments of Petitioners and certain *amici curiae*, the physical and financial separation requirements are neither arbitrary and capricious, nor inflexible.[48]

3. The interchangeable definitions of "program" and "project" [49] are necessary to avoid the use of accounting and bookkeeping techniques by Title X-funded entities to "separate" their abortion and non-abortion activities. Similarly, these definitions are necessary to ensure that no program or project which is approved for funding by HHS under Title X is employing program or project funds for prohibited purposes—whether or not those

[48] For further discussion of this point, see Brief of the American Academy of Medical Ethics as *Amicus Curiae* in Support of Respondent ("AAME Brief").

[49] 42 C.F.R. 59.2.

funds are received directly from the federal government.[50] The necessity for this restriction is clear. The government should be free to demand, in funding a particular program, that the program carry out the purposes for which the government has selected it, and *not* carry out purposes to which the government is opposed. These definitions do not mean that an entire *organization* is prevented from receiving Title X funds if a separate program within that organization engages in practices outside the scope of Title X.[51] However, they do mean that Title X funds will not go to specific programs which engage in these practices.

B. The Requirement of Referral to Prenatal Care Providers Will Not Adversely Affect the Health Interests of Women.

Title X is not a maternal or infant and child health care program. Nothing in the legislative history suggests otherwise. Indeed, a large amount of Title X funds are distributed to freestanding clinics, which lack the ability to provide general prenatal and obstetrical care. Given these basic limitations of the Title X program, and the urgent need for pregnant women (especially the poor) to receive early prenatal care, Title X clinics should refer their pregnant patients immediately to sources where such care can be obtained. Thus, the requirement of § 59.8, that the pregnant client be furnished "a list of available providers that promote the welfare of mother and unborn child," is clearly in the best interests of these pregnant clients.

[50] The definition of "program" is consistent with that generally employed by the Public Health Service. *See* PHS Grants Policy Statement, Department of Health and Human Services 4 (Rev. 1987) ("program" defined in part as "[a] coherent assembly of plans, projected activities, and supporting resources contained within an administrative framework, whose purpose is to implement an organization's mission or some specific program-related aspect of that mission.")

[51] *See* AAME Brief, *supra* note 48.

Petitioners' objections to this requirement are unavailing. They assert that the Regulations will harm maternal health because women will not be properly informed of the abortion option, even when that option is medically indicated. This reflects the Petitioners' underlying theory, that the Regulations impose an unauthorized barrier between Title X programs and access to a necessary reproductive health service, i.e., abortion. However, both the theory and the assertion are flawed because they misrepresent the status of abortion as a medically necessary procedure; they ignore the potential physical and psychological complications of abortion; and they misconstrue how these regulations apply to cases where a pregnancy poses a genuine risk to maternal health.

1. ***Where Medical Indications for Abortion Are Present, a Title X Clinic Should Refer the Patient to a Specialist in Her Underlying Condition for Care and Counseling.***

Abortion is, almost exclusively, an elective procedure. Medical indications for abortion are limited, particularly in the case of first-trimester abortion.[52] Among the commonly-cited medical conditions in which a physician purportedly "must advise a woman that abortion is an option she should consider" [53] are diabetes, cardiac disease, and certain forms of cancer. However, these conditions almost never require an immediate referral for abortion; rather, they require that a woman be referred immediately to a specialist in her underlying condition. That specialist, not a family planning clinic (and certainly not an abortion clinic), is the only party qualified to counsel a woman regarding the relative risks of continuing the pregnancy to term and abortion. The proper role for the Title X clinic in such a case is referral to the appropriate specialist, a course of action that is already mandated by pre-existing Title X regulations. 42 C.F.R. § 59.5(b)(1) (requiring projects to "[p]rovide for . . . necessary referral to other medical facilities when medically indicated.")

[52] The term "abortion," as used herein, does not refer to a procedure to remove the fallopian tube in which an ectopic pregnancy has implanted. Such a procedure is clearly within the scope of the "emergency care" exception to Section 59.8 of the Regulations.

[53] Brief of Amici Curiae Planned Parenthood and NFPRHA, *supra*, note 20 at 8.

For example, immediate counseling of a pregnant client with diabetes regarding abortion is clearly not mandatory. Advances in the management of pregnancy for diabetics result in birth outcomes that are nearly equivalent to those for non-diabetic mothers.[54] The non-deformed offspring of diabetic women have a perinatal mortality rate that is virtually equivalent to that of the offspring of non-diabetic women: provided that their mothers receive proper prenatal care.[55] Thus, these women can be successfully managed in their pregnancies, and abortion is not medically indicated.[56]

Similarly, "[t]he majority of cardiac patients can enjoy a successful pregnancy outcome." [57] The exceptions to this statement include patients with pulmonary hypertension, Marfan's syndrome, and patients with poor outcomes after corrective surgery, or with advanced coronary artery disease.[58] Such patients are or should be under the care of a cardiologist or other specialist. Those who are not, and are diagnosed as pregnant by a Title X clinic, should be immediately referred to such a special-

[54] Freinkel, *et al.*, *Care of the Pregnant Woman with Insulin-Dependent Diabetes Mellitus*, 313 New Eng. J. Med. 96 (1985).

[55] C. Pauerstein, ed., *Clinical Obstetrics and Gynecology*, 667 (1987). This figure excludes deaths due to major congenital deformations, which are themselves becoming more rare in cases of pregnant diabetics. *Id.* at 674.

[56] Pauerstein, *supra* note 55 at 667-674.

[57] Pauerstein, *supra* note 55, at 630.

[58] *Id.* at 630.

ist for further care and counseling, both of which lie outside the "family planning" specialty.[59]

Abortion is also not generally indicated for pregnant women suffering from breast cancer. "The few clinical reports that detail survival in patients who aborted early in pregnancy demonstrate no subsequent advantage gained by that intervention." [60] Other clinical studies show no statistically significant difference between the survival rate of women whose breast cancer occurred during a pregnancy and other breast cancer patients.[61] Medical indications for termination of pregnancy to save the mother's life, arise only in very limited circumstances.[62] Obviously, a woman in such a condition should not be under the care of a Title X clinic, but under the care of an oncologist or other specialist.

The picture is the same with regard to pregnancy and other malignancies, including Hodgkin's Disease,[63] brain

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[59] The small likelihood that cardiac patients for whom abortion may be indicated will not already be under the care of a physician *other* than a Title X clinic physician is illustrated by the functional description of their disease classification. Therapeutic abortion is indicated only for those patients with a marked or total limitation upon normal physical activity, and for whom physical activity results in fatigue, palpitation, dyspnea, or anginal pain. Pauerstein, *supra* note 55 at 630. A patient in such a condition, if not already under the care of a cardiac specialist, should immediately be referred to one.

[60] Pauerstein, *supra* note 55, at 809, *citing*, DiSaia, P.J. & Creasman, W. T., *Clinical Gynecologic Oncology* (2d ed. 1984) at 428-464.

[61] Pauerstein, *supra* note 55, at 809.

[62] *Id.* at 809.

[63] *Id.* at 812 ("Pregnancy has no effect on the disease, and therapeutic abortion does not increase survival." Early delivery or therapeutic abortion may be indicated primarily where there is concern over teratogenic effect of treatment upon unborn child.)

tumors,[64] and leukemia. Abortion may be considered, but this must be done in conjunction with a full review of the effect of available therapeutic options on both the mother and the fetus, and the possibility of adjusting therapy to the mother which might allow the birth of a healthy infant.[65] The treatment and management of cancer, and the management of pregnancy in a woman so afflicted, are outside the conceivable scope of services in a Title X clinic. Where a Title X clinic suspects that a pregnant woman may have cancer, that clinic *must* refer to a competent specialist in that field. This is required by § 59.5 (b) (1) of the current regulations.

2. *Abortion Imposes a Risk of Physical and Psychological Harm to Women.*

The physical and psychological risks of a medical procedure are relevant to any decision whether or not to undergo that procedure. This is likewise true of abortion when utilized as a means of family planning. However, the 1981 "options counseling" Guidelines of HHS did not require Title X grantees to provide any information regarding such risks, and instead, permitted immediate referral of pregnant clients to entities which specialize in the performance of abortions. Thus, clients could be counseled as to their "options," without complete information as to the consequences of their decision.

Petitioners and their *amici* focus upon the purported risks of child-bearing, but disregard the genuine risks to maternal life and health posed by abortion. In fact, Petitioners discuss abortion as if it were risk-free. This is not the case.[66] The legalization of abortion has not had

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[64] *Id.* at 826-827 (management of pregnancy is possible; therapeutic abortion may be recommended because of rapid progression of symptoms and high mortality).

[65] *Id.* at 803.

[66] *See, The "Abortion Profiteers,"* Chicago Sun-Times, Nov. 12, 1978 (results of five-month detailed investigation into conditions

a dramatic impact in reducing abortion-related maternal mortality. The Centers for Disease Control reported a total of 175 abortion deaths between 1972 and 1981, 83 of which were associated with first-trimester abortions.[67] CDC experts admitted that "it is likely that CDC has not identified all abortion deaths in the United States," and that while CDC's counting of abortion deaths is the most comprehensive available, the numbers "may also reflect an undercount of the true number of total deaths."[68] Both overall and abortion-related maternal mortality have been on a steady downward trend for decades, and "the legalization of abortion has had no effect" on this trend.[69]

Furthermore, claims that "abortion is safer than childbirth" are compromised not only by the likelihood that deaths relating to abortion are underreported, but also by the fact that the methods employed by some statisticians do not present a valid comparison between abortion and childbirth. For example, most studies consider as deaths related to "childbirth" virtually *all* cases of maternal mortality not related to induced abortion, whenever they occur. When comparison is made between abortion and natural pregnancy during corresponding

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at clinics in Chicago); *Tragic End to Ghanaian's Dream*, Newsday, June 9, 1989, at 6 (death of 28-year old immigrant after abortion at unregulated "storefront" clinic in Brooklyn); *Hospital Shut Down as Health Risk Will Reopen for Abortions Tomorrow*, Los Angeles Herald Examiner, Feb. 12, 1988, at A-1.

[67] *Hodgson v. Minnesota*, 3-81-Civil-538 (D. Minn. 1986), Tr. at 2125 (Testimony of Richard T.F. Schmidt, past president, American College of Obstetricians and Gynecologists, *citing*, *Abortion Surveillance 1985*, U.S. Dept. of Health and Human Services, Centers for Disease Control.)

[68] Cates, *et al.*, *Morality from Abortion and Childbirth: Are the Statistics Biased?*, 248 J.A.M.A. 192, 193 (1982).

[69] Hilgers and O'Hare, *Abortion Related Material Mortality: An In-Depth Analysis*, in New Perspectives on Human Abortion, 69, 73 (Hilgers, Horan, Mall, ed., 1981).

periods of gestation, natural pregnancy is shown to be *safer* than induced abortion.[70]

The potential non-lethal complications of induced abortion, although often minimized, have also been documented in the medical literature. A leading textbook acknowledges that "[i]n medical practice there are few surgical procedures given so little attention and so underrated in its potential hazards as abortion."[71] Cates and Grimes, who have consistently advocated the relative safety of abortion,[72] nevertheless acknowledge that in absolute medical and economic terms, the incidence of maternal mortality and morbidity is significant:

> The scope of the problem of abortion complications is large, both numerically and economically. For exemple, in 1977, nearly 100,000 women in the United States sustained complications of abortion, and 16 died. . . . Excluding the indirect cost of treating women who suffered complications in 1977 was over $22 million.[37]

Finally, abortion poses significant risks of psychological harm, including depression, obsession, prolonged guilt and anger, and isolation.[74]

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[70] *See*, Hilgers & O'Hare, *supra*, at 86-89 (comparison of maternal mortality rates from induced abortion and natural pregnancy during first 20 weeks and final 20 weeks of pregnancy); Lanska, *et al.*, *Mortality from Abortion and Childbirth*, 250 J.A.M.A. 361-362 (1983) (correspondence noting maternal mortality rate for *vaginal* deliveries is less than death-to-case rate for legal abortions.)

[71] W.H. Hern, M.D., *Abortion Practice* 101 (1984).

[72] *See, e.g.*, LeBolt, Grimes & Cates, *Mortality From Abortion and Childbirth*, 248 J.A.M.A. 188 (1982).

[73] Grimes & Cates, *Abortion: Methods and Complications*, in *Human Reproduction*, 2d ed., Reprinted by U.S. Public Health Service, Dept. of Health and Human Services.

[74] Note, *Abortion Counseling: To Benefit Maternal Health*, 15 Am. J. of Law & Med. 483, 488-490 (1989); A. Speckhard, *The Psycho-Social Aspects of Stress Following Abortion* (1987).

The risks of maternal mortality and morbidity, and psychological harm, are clearly relevant to any voluntary and informed decision regarding abortion.[75] Yet, neither the "options counseling" Guidelines issued by HHS in 1981, nor the counseling training materials used by Title X grantees, mandate discussion of these risks. This seriously compromises Petitioners' claim that nondirective "options counseling" is the appropriate response to an unplanned pregnancy.

Rather than reform these Guidelines to require more extensive counseling regarding abortion and childbirth, the Secretary has determined that this counseling should not be provided at all under Title X, but is more properly the domain of those entities who provide prenatal and/or abortion services. This is clearly a rational determination, made more so by the constitutional uncertainty regarding "informed consent" requirements for abortion. *See, Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983).

3. *The Regulations Impose No Burden on Access to Appropriate Medical Care in Situations of Medical Emergency or Necessity.*

The Conference Report on Title X stated that it was "the intent of both Houses that the funds authorized under this legislation be used only to support *preventive* family planning services, population research, infertility services, and other related medical, informational, and educational activities." Conf. Rep. No. 91-1667, 91st Cong, 2d Sess., U.S. Code, Cong. & Admin. News at 5080, 5081-5082 (1970) (emphasis supplied). Title X funds, therefore, were not to used for non-preventive family planning, i.e., abortion, or for post-conception prenatal care and services. Nor were Title X grantees expected to assume the role of other health care providers. Rather, grantees were to fill a need not being met by other providers, and supply a resource to these providers on family planning questions. Thus, referral from the Title X clinic to other sources of care is the proper means for the clinic, in the case of a pregnant client, to "integrate" with the general health care system.

For those situations in which pregnancy poses a threat to maternal life or health, or in which pregnancy causes a medical emergency, the new Regulations do not restrict access to appropriate medical care, even if that includes an induced abortion or early delivery. First, the regulations provide a specific exemption for "emergency care," and require Title X recipients "to refer the client immediately to an appropriate provider of emergency medical services." 42 C.F.R. § 59.8(a)(2). Second, § 59.5(b)(1) of the Regulations requires Title X projects to provide necessary referrals to other medical facilities where indicated. Third, the regulations allow referral to providers of prenatal care which may also perform abortions.

Therefore, a Title X client whose condition calls for consideration of abortion will not be denied access to that advice. Rather, the client, under the new Regulations, will be referred to a medical provider capable of assessing and managing a high-risk pregnancy. In such circumstances, abortion is not a "method of family planning," and therefore, neither the prohibition of Section 1008, nor the specific restrictions of these Regulations, apply. However, the existence of such circumstances do not deprive the Secretary of the authority to require that, in general, the pregnant clients of Title X clinics receive referrals to prenatal care.

Finally, the new Regulations neither require nor permit the abandonment of the pregnant Title X client. Once the appropriate referral is made, that client "must be provided with information to protect the health of

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[75] *See* Note, *Abortion Counseling, supra* note 74 at 492-494 ("Many women experience more anger following the abortion, specifically at abortion personnel, if the women believe the counseling is inadequate.")

mother and unborn child until such time as the referral appointment is kept." 42 C.F.R. § 59.8(a)(2).

CONCLUSION

The decision of the Court of Appeals should be affirmed.

Respectfully submitted,

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APPENDIX

APPENDIX [1]

ABORTION IN THE UNITED STATES

The following chart was compiled from data published by researchers affiliated with the prochoice Alan Guttmacher Institute. They have compiled the most complete and reliable data about abortion in the United States. (The Center for Disease Control publishes abortion statistics also, but it uses state-gathered information, whereas A.G.I. also obtains data from abortion providers). Thus, some C.D.C. annual abortion reports have been 15% underinclusive. *See* C. TIETZE, INDUCED ABORTION: A WORLD REVIEW, 1981, at 19-26 (1981).

Year Married	Number of Abortions Late [a] *** [b]	Abortion Rate * [a]	Abortion Ratio ** [a]	% Repeat *** [b]	% Under 19 Yrs. [b]	% Not Married [b]	Past 1st Trimester **** [b]
1972	587,000	—	—	—	—	—	—
1973	745,000	16.3	193	—	32.8	71.0	14.6
1974	899,000	19.3	220	15.2	32.5	72.4	12.0
1975	1,034,000	21.7	249	20.5	32.9	73.7	10.8
1976	1,179,000	24.2	265	22.7	32.1	75.4	9.8
1977	1,317,000	26.4	286	26.6	31.3	77.2	9.0
1978	1,410,000	27.7	294	29.5	30.8	76.5	8.9
1979	1,498,000	28.8	297	31.7	30.8	78.5	8.8
1980	1,554,000	29.3	300	33.0	29.6	79.4	8.7
1981	1,577,000	29.3	300	35.1	28.5	81.1	8.8
1982	1,574,000†	28.8	299	36.8	27.5	80.9	8.1
1983	1,575,000‡	27.4	294	38.8	27.1	81.3	9.5
1984	1,577,000	28.1	297	—	—	—	—
1985	1,589,000	28.0	298	—	—	—	—
1986	—	—	—	—	—	—	—
1987	—	—	—	42.9	25.5	81.5	—

[1] This Table originally appeared in Wardle, *"Time Enough"*: Webster v. Reproductive Health Services *and the Prudent Pace of Justice*, 41 Fla. L. Rev. 881, 985-986 (1989). Reprinted with permission of the Florida Law Review, © 1989.

* Per 1,000 women 15-44

** Per 1,000 known pregnancies (live births plus abortions)

*** Women having second or more abortion

**** Thirteen or more weeks from last menstrual period

[a] CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE, ANNUAL SUMMARY, 1978, at Table 1 (1980) (for 1972); Henshaw, *Trends in Abortion, 1982-84*, 18 FAM. PLAN. PERSP. 34 (1986); Henshaw, Forrest & Blaine,

Abortion Services in the United States, 1981 and 1982, 16 FAM. PLAN. PERSP. 119, 121 (1984) (for 1981-82); Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 FAM. PLAN. PERSP. 63 (1987) (for 1985); Henshaw, Forrest, Sullivan & Titeze, *Abortion Services in the United States, 1979 and 1980*, 14 FAM. PLAN. PERSP. 1, 6 (1982) (for 1973-80) estimated 3%-6% shortfall in data); *Contraception and Abortion Costs Are Tiny Portion of U.S. Health Spending*, 18 FAM. PLAN. PERSP. 37 (1986).

[b] Forrest, Sullivan & Tietze, *Abortion in the United States, 1977-78*, 11 FAM. PERSP. 329 (1979) (for 1973-78); Henshaw, *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients*, 20 FAM. PLAN. PERSP. 158 (1988) (for 1987); Henshaw, *Characteristics of U.S. Women Having Abortions, 1982-1983*, 19 FAM. PLAN. PERSP. 5 (1987) (for 1982-83); Henshaw, Binkin, Blaine & Smith, *A Portrait of American Women Who Obtain Abortions*, 17 FAM. PLAN. PERSP. 90 (1985) (for 1980-81); Henshaw & O'Reilly, *Characteristics of Abortion Patients in the United States, 1979 and 1980*, 15 FAM. PLAN. PERSP. 5 (1983) (for 1979-80).

† Total cost for all abortions in 1982—$484 million.

‡ Average amount paid for *1,068,000 first-trimester abortions* in 1983—*$200 per abortion.*